There are long waiting lines for service, doctors are scarce, the quality of medical care is poor, it costs too much, and it results in rationed health care. When the government is running health care, people die. Now the administration is forcing universal health care on everybody.

Let's look at some of our history on American-run health care: when Stephanie Little Light took her daughter, Ta'Shon Rain, to the Indian Health Service Clinic in Montana, which she was required to do since she is under the universal health care Indian program, the doctor said her little 5-year-old girl was just depressed. She had stopped eating and stopped walking. The little girl kept complaining to her mom that her stomach hurt. And after going back to the government-run health care clinic 10 more times, Ta'Shon's lung collapsed.

She was air-lifted to a private, non-government hospital in Denver where they told her mom she had terminal cancer. The little girl who loved to dance and sing and dress up in Indian costumes always wanted to see Cinderella's World at Disney World. A charity sent the whole family there, but Ta'Shon didn't get to see the castle when they got to Florida. The little girl had died in her hotel room. The mother says she still cries when she remembers how her daughter was always in pain before she died.

There are more examples. The doctors at the Indian Health-run clinic told Stephanie there was nothing wrong with her daughter, that she just had all of this in her mind.

This is a tragic example of medical health care run by the United States Government. There is a big difference between good intentions and what really happens in the real world. When there are no doctors left and the taxpayer money is gone and when bureaucrats control health care, people die. Is this what we are to expect under the new nationalized health care system?

□ 1530

Mr. Speaker, they say on these Indian reservations don't get sick after June because that's when all the Federal money runs out. So they ration health care.

The Indian Health Service Agency calls itself, get this, a ''rationed health care system.'' How's that for truth about socialized medicine?

Rhonda Sandland lives on Standing Rock Reservation in North Dakota. She'd had a terrible case of frostbite on both her hands, and her hands had turned purple. The pain got so bad that she could not even dress herself. She visited the Indian Health Service clinic over and over again. Rhonda says she didn't get any help there until she threatened to kill herself because of the pain. The clinic then decided to cut off five of her fingers. Lucky for Rhonda there was a private doctor that just happened to be visiting the reservation. He prescribed her medicine that she needed, instead of cutting off her fingers. She's okay today.

Victor Brave Thunder was not so fortunate. He felt real bad and he went to the same government clinic as Rhonda. They misdiagnosed the fact that he had heart failure, and gave him Tylenol and cough syrup. He later died.

Marcella Buckley has access to all the free government health care she can stand. Once again, she's required to go to the government Indian Health Care Services. Marcella had stomach pains and went to the government clinic on her Indian reservation for 4 years. She was given a whole host of reasons for her stomach pain, including the fact, they said, she might have a tapeworm. Eventually she found out she had Stage 4 stomach cancer, and it had spread all over her body. Now she seeks treatment at a private provider.

On another Indian reservation, Ardel Baker went to her government-run clinic because she had chest pains. They sent her in an ambulance to a private hospital where she noticed that they had put a note on her chest in the ambulance. And the note read, ''Understand that Priority 1 care cannot be paid for by us at this time because of funding issues.'' So they put a note on her, send her on her way to a private hospital because they can't take care of her. Ardel managed to survive that ordeal, thanks to private medicine.

But it was too late for Harriet Archambault. Harriet died when her hypertension medicine ran out. She tried five times to get an appointment to refill that medicine. Government bureaucrats nowhere to be found. So she died before she could ask for that sixth appointment at that government clinic.

Mr. Speaker, these are examples of government-run medical malpractice against the Indians right here in America. Government-run health care never works. Even in America we've proven it doesn't work.

And, Mr. Speaker, I will just close by saying this: If you love the way we run the Postal Service, and you love the way that we run FEMA, and you love the compassion of the IRS, you will love the new nationalized health care system. Just ask the American Indians.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. SCHIFF) is recognized for 5 minutes.

(Mr. SCHIFF addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Kansas (Mr. MORAN) is recognized for 5 minutes.

(Mr. MORAN of Kansas addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

(Ms. KAPTUR addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. DREIER) is recognized for 5 minutes.

(Mr. DREIER addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DEFAZIO) is recognized for 5 minutes.

(Mr. DEFAZIO addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan (Mr. MCCOTTER) is recognized for 5 minutes.

(Mr. MCCOTTER addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Nevada (Ms. BERKLEY) is recognized for 5 minutes.

(Ms. BERKLEY addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Arizona (Mr. FRANKS) is recognized for 5 minutes.

(Mr. FRANKS of Arizona addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

THE WORLD'S GREATEST DELIBERATIVE BODY

The SPEAKER pro tempore (Ms. KOSMAS). Under the Speaker's announced policy of January 6, 2009, the gentleman from Iowa (Mr. KING) is recognized for 60 minutes as the designee of the minority leader.

Mr. KING of Iowa. Madam Speaker, I appreciate being recognized to address here on the floor of the House of the House of Representatives. This has often been described as the world's greatest deliberative body. And here, in these Chambers, we engage in this debate and this dialogue.

But the dialogue that comes to these Chambers is a dialogue that's designed to be filtered through our committee system, through our subcommittees, through our full committee process, whether it be the appropriations subcommittees and committees and on to the floor, or whether it be through our standing committees. And what we've seen happen instead is that this process is under the process of a wrecking ball that's been taken to the traditions of

this House. And each day that goes by, it seems that there's another one of those opportunities to expand this deliberative body and, instead, it's diminished by order of the Speaker, by order of the Rules Committee; shut down the process to the point today where we had the gentleman from Oregon brought a privileged resolution to try to be heard on an amendment that would have otherwise been in order under 220 years of tradition of this House, but, instead, it was shut down by the Rules Committee, the committee that serves up here in this little hole in the wall in a room so small that a few Members can come in. Once in a while there's room for their staff. I have never seen press in the room. There is no camera in the room, and there will be no tourists that are allowed to go in there and watch the real debate that takes place, if it takes place at all in this Congress, in the Rules Committee. It's been changed that way in order to avoid the light of day, the press, the C–SPAN cameras and, in fact, even some of the record-keeping that is a little bit different there than it might be if it were up in front of everybody in front of the television cameras. And it is of great frustration to most Members of this Congress to see what's being done to this debate and deliberative process.

So these debates that take place here on the floor, we used to have some good debates, some engaging debates, some times when people actually changed their minds when they heard the other side of the argument. That's what makes this the greatest deliberative body in the world. But now the debate's been reduced to something that takes place behind closed doors, I believe, by order of the Speaker, and amendments are shut down time after time after time. At least a dozen of mine were struck through just in the last couple of days. And I have sat up there waiting my turn to testify in the Rules Committee to the extent where I really want to bring up a laptop and some other kind of book work so I can make my time count. And if you get up and go to get a bite to eat or something to drink, then you might lose your turn altogether.

So I have, Madam Speaker, introduced legislation that, if the business of this House is actually going to be conducted by the Rules Committee, then let's move the committee to the floor of the House of Representatives. If you're going to change and usurp the genuine authority of the franchise of all 435 Members of Congress who have a constitutional right and duty to express the will and the wishes of their constituents by amending the process, offering amendments, seeking to improve legislation, if the rules are going to be such that they usurp the authority or the franchise of each Member and put it up behind closed doors—and the doors are closed. And as I sat there waiting my turn, last week, well, it's still this week, I had two of my own staff people waiting out in the hallway. They couldn't even get in to hand me a piece of paperwork. I have to send them an e-mail on my BlackBerry and they'll pass the paperwork in because there wasn't room.

The business of the Congress is being conducted either in the Rules Committee, or behind the scenes, behind the Rules Committee, but it's not being conducted on the floor of the House.

So when Members are denied amendments that would be in order under the 220 years of the tradition of the House of Representatives, but the ones that are allowed will be a whole series of amendments offered by the gentleman from Arizona to strike a little funding here, to strike a little funding there, most of which I voted for, by the way, Madam Speaker, it gives the image to the public that there's a legitimate debate going on here, but it is not the legitimate debate. And, in fact, if you listen to the debate, there's no exchange of ideas. There's no clash of the contest of competing ideas. There's not an exchange of dialogue. It's rare to have a Democrat yield when asked to yield by a Republican who simply wants to clarify a fact or make a point that would better bring out something in the debate that would be good for the American public to know.

This process has devolved down to where it can't be called any longer a deliberative process. And the American people do care about whether their voice is heard in this Congress. And it's not being heard in this Congress.

As we've watched things be rushed through, the cap-and-trade bill, which I call the cap-and-tax bill, rammed through here to where a bill was hurried up and rushed, and then, to have an opportunity to amend the bill didn't exist for Members of Congress. It did exist for the manager, apparently, because there was a 316-page amendment that was brought down here and dropped into the record at 3:09 in the morning, to stack that on top of a 1,100-page bill that nobody read.

And the most colossal mistake in the history of the House of Representatives was the passage of the cap-and-trade bill. And it was done so with no Member of Congress having read the bill, not one. And no Member of Congress read the amendment, not one. And if they'd read them separately, they couldn't understand the composition of the bill because the 316-page amendment that was dropped on us at 3:09 in the morning was not integrated into the overall bill. It was impossible to do that. You've got to page forward and back and go back into the code and verify the references and rewrite to get this 316-page amendment blended into and integrated into the overall bill.

And when the question was asked of the Speaker during the debate, is there a copy of the enrolled bill here in the House, there was no copy, Madam Speaker. There was no bill. We were debating something that didn't exist yet. And we passed something that didn't exist yet. And Members were required to vote on a bill that was 1,400-plus pages in its aggregate form, not having ever had it integrated, but that anybody understood the complete context, within the context, the complete content of the overall bill and the amendment. But Members voted anyway. And even though the Speaker said that she was going to provide for sometimes 72, otherwise 48 hours to be able to fully evaluate the consequences or the merits of the legislation that would come before the floor, that didn't happen. It seldom happens.

This place is being run with an iron fist, not with the open kind of a process that was promised when people put their trust in the current majority to run this Congress in a legitimate fashion. It's not legitimate. We can't even put up the front that it's legitimate if we are debating a bill that no one, and I mean no one on the planet, has completely read, and an amendment that no one understands completely how it integrates with the overall bill, and to be able——

We stopped the process here for over a half-hour while we tried to get a copy of the language that was being voted upon. And we never got it done. To the credit of the Clerk, she was actively trying to integrate the amendment into the overall bill, but it could not be done within the time that was available. And even if it had been, it was only symbolic because still, no one would have had a chance to read it.

And I'll even take this to this wild outrageous step of we ought to understand the things that we are voting upon. We should be able to get our hands on it. We should have time to read it, deliberate it, consider it, and pass it out to our constituents, and they should have access to it over the Internet, and they should be able to give us input on how it affects their lives. We can't bring the wisdom of Solomon with us, everyone in here, and instantaneously make a decision and a snap judgment on something there's no opportunity to read.

And it was an embarrassment, I know, for the majority to be debating a huge bill, a colossal bill, a cap-and-trade bill, and not even having one single, not even a symbolic version for somebody to point to and say, This stack of paper is what is going to save the planet—I think, is the position that the Speaker took.

And so the question was asked by the gentleman from Texas (Mr. GOHMERT), Madam Speaker, can we message this bill over to—if this passes, this bill that was before us, if it passes the House, if we don't have a bill, can we still message it over to the Senate? Or do we just tell them we sent you over a bill that we passed but it's not ready for anybody to review. It's not been reviewed yet.

That's the fact of what we were dealing with when the cap-and-tax bill was passed. And now it's messaged to the

Senate. Presumably, somebody's put it all in its proper form. But I'm confident that not one Member of this House of Representatives has yet read that bill because now it doesn't pay. They can't shut themselves up and invest the time in reading the cap-and-tax bill because it's already passed the House, nobody having read it and no version of it in its complete form being available to any Member; messaged over to the Senate. I don't know if it was the stack of the bill and then plus the 316 pages in an amendment separately, or if it got messaged over there integrated in a fashion that they could say that they received a complete bill in the Senate. We don't know. And it doesn't really matter to the House Members because we now have another bill that's coming at us so fast and so hard that hardly anyone has a chance to read it, although I do know a couple of Members that have burned a lot of midnight oil and tried to get through it. They have to break it apart and assign it to their staff and read the parts they can as fast as they can, and others will read it and write their little memos on it. That's this health care bill. Oh, my. You should see what we have here now that's been cooked up by the staff.

□ 1545

This work was done urgently and, I think, effectively off of the components of the bill that were available, and I think this might actually be representative of what we have today.

This is the flowchart, Madam Speaker. This is the schematic of what is created by this idea of a public plan for health insurance and to provide health care for the people in America. I have to point out that these white boxes on this schematic flowchart—in places like Australia, they would not call it a ''flowchart.'' They would call it a ''scheme.'' I'll stop a little short of that one; but the white ones are the existing agencies and programs that are there, and the colored ones are the new ones.

So you'll see a number here that's, maybe, oh, about an equal number of new agencies matching up with the equal number of existing agencies. As you read down through this, there are all kinds of components to this that ought to scare any freedom-loving person, but the one I'd direct your attention to, Madam Speaker, is down here at the bottom, these two circles that are in purple in the blue background.

Now, the left-hand circle is this: It takes the traditional health insurance plans—the white that's existing—and now they'll have to qualify, and they'll have to qualify so that they'll meet the Obama standard for new health insurance companies. So, if you're an American citizen with a health insurance plan that you like and if you want to keep what you have for a little while, you can keep what you have, but the insurance company will have to comply with the new standards that will be written by the existing or future health insurance czar. Surely, we have one or will have one. We have 32 czars. We couldn't have nationalized health care without a health insurance czar.

So that czar will be writing the rules—it's not in the bill—on what it takes for the traditional health insurance plans to qualify to become the qualified health benefits plans. That's the private side. That's your health insurance if you're an American citizen—a person who has a plan that's not either Medicaid or Medicare. They have to qualify. It changes every one of them, potentially meeting a new standard that would be set by the health insurance czar. The health insurance companies, the ones that survive, will be fewer than the 1,300 we have today, the 1,300 competing against each other, the insurance companies that are providing different models to try to get the investment dollar in there, the premium dollar, from the people of whom 70 percent are happy with the health insurance plans that they have. We won't have 1,300 when they're done complying with the White House health insurance czar standards. We'll have less. I don't know how many less, and nobody knows, because we don't know what the standards will be; but these private companies then will have to compete with the newly created, if this bill passes, public health plan. The public health plan will be the Federal health insurance plan that is there to compete against the private plans.

Now, why would they want to do that? Why would they create a whole plan for the government to run with taxpayers on the hook if they've got 1,300 health insurance companies today that are more than happy to get out there and to continue to compete in the marketplace? What would be the merits?

Well, the only ones that I can determine are—if you really wanted to establish a national health care plan that didn't have competition, if you wanted everybody on a single-payer plan, if you wanted to have nationalized health care, if you wanted socialized medicine, you can't do that without first creating some kind of a public health model, and that is what this new public health insurance model would be. Over time, it would, I believe, compete and would push out of the marketplace every one of these health insurance programs that we know today because the government would subsidize.

I'll give you an example of how this works. Since we don't have insight into this in the United States on Federal competition against the private sector with regard to health insurance, here is a model:

Flood insurance, the flood insurance that we used to have that was property and casualty insurance for people who were living in flood plains or for people who were afraid that they'd be flooded. They would buy their insurance in years back and would pay the premiums. If they got flooded, the flood insurance companies would come to their places and they'd take a look at the damage. They'd write them checks and they'd settle it out. That's how it works in the insurance industry in a lot of different ways. In the property and casualty at least it does.

The Federal Government decided that there wasn't enough competition in the flood insurance business, so they set up Federal flood insurance years back to compete against the private-sector flood insurance plans that were there. Actually, yesterday I checked into this, and I was not able to discover a single company in America that is selling flood insurance in competition against the Federal Government. The Federal Government has established a monopoly now in flood insurance. Now, two things can happen if you have a monopoly. You can price it way out of the marketplace, and if you have a captive market, you can do that, or if you have a marketplace that you're trying to market to in your government, then you can undersell your costs by lowering the premiums below the actual costs, which is what the Federal Government has done.

So, today, the Federal flood insurance program, the only existing flood insurance program in the United States of America, is the flood insurance program that's $18 billion in the red. That's $18 billion in the red because it's government. We should not be surprised at this. The government came into the marketplace subsidized by tax dollars, and it lowered the premiums for flood insurance, but by lowering the premiums, they took the private sector competition out of the marketplace. They went off to do other property and casualty. They cleaned the field out and became the monopoly holder of all of the flood insurance of America. Yet they still couldn't set the premiums at the risk. They set the premiums at, apparently, what their bureaucrats thought they should be at, and they're $18 billion in the red.

Now, imagine what that would be like if it were the post office and if everybody had to go and buy a stamp. We are critical of the post office when they can't hold their balance sheet in the black, and they are marginally in the red today.

That's the government program flood insurance, running in the red at $18 billion, and that, Madam Speaker, I predict, is what will happen with our health insurance in America.

So, when President Obama says, If you like your health insurance, don't worry; you can keep it. You can't keep it if it doesn't exist. How could anybody have kept their flood insurance if there are no companies selling flood insurance except the Federal Government's flood plan?

What if the health insurance czar writes the specifications for these companies to qualify at such a standard that they can't compete with the public plan? Why would the health insurance czar not write those regulations

so that they would be at an advantage to the newly emerging public health plan? After all, they have to find a way to compete in a marketplace that is competitive.

So the model is there. If people think that I just pulled off the shelf a model that happens to make my case, I would make the point of: show me a model where government has gone in and has taken over where they didn't squeeze out the private sector.

Should we talk about crop insurance, for example? That would be another model. How about student loans for another model? Students loans used to be private. Then the government got into the business, and now they've taken the student loan program down to where only about 25 percent of the student loans are private and the rest of them are government-brokered student loans. We have now the chairman of the Education and Labor Committee and many others who simply want to eliminate any student loans except what are government student loans.

When government steps into the private sector, a number of things happen: The quality of the service goes down. The cost of the service goes up because you get inefficiencies that come in with government that would be automatically erased by the competition from the private sector. Then you either get rationing or you get rates that go up or you get taxes that are increased. In the case of flood insurance, it is that taxes have increased to pick up the $18 billion shortfall that is there. So we know the pattern. We know the drill. We should know what this is. We've been through this before, Madam Speaker.

To make the point that we've been through this before, here is my ''deja vu all over again'' chart. The ''deja vu all over again'' chart is the schematic, the flowchart—as the Aussies would say, it's the scheme—from back in 1993. This is HillaryCare. I remember this coming out during that period of time. I have a chart that must exist in my archives, a chart that hung on the wall in my construction office during those years. I would stand and look at that and study it when I would be on the phone while I would be pacing back and forth. I would walk by and look at this chart of HillaryCare. I would look at all of these created agencies and at the interconnectivity of them. It was something that chilled me and that galvanized me. It was one of the significant stepping stones along the way for me to go from the private sector of 28 years in the construction business into the legislative arena because I was so appalled by what I saw them doing to create more government that would be oppressive to the freedoms that I so love and enjoy.

This is about freedom. This is about whether we are going to keep and maintain our freedom and expand our freedom or whether we're going to trade that off for a dependency and accept the dependency that comes from a government plan that has a bunch of, I want to say, elitist, liberal-thinking people who think that the American people can't make their own decisions, so they have to make the decisions for us.

It's the same kind of thinking that would take the deliberation of the House of Representatives up in the hole in the wall in the House Rules Committee and let the Rules Committee take the orders from the Speaker's office and not allow it to come down here to be heard in the light of day. They think they know. They think they're smarter than you. They think they can draft a proposal that is a utopian model of health care for the United States of America, and they will tell you they can save money. They don't actually tell you that you're going to get better service, because this is the best health care system in the world. We don't wait in line. We don't have to take a number. We don't get hurt and lay around waiting for somebody to come along and take care of us. We don't stand in line. Americans should not stand in line.

I can think of the times I've had to do that, and it grates on me. I don't like standing in line at TSA to get on a plane. I remember who brought that about. That's the terrorists. We ought to always blame them. I don't like to stand in line with my credit card in order to pay a bill, and the retailers know that. They don't allow lines out there, because you won't make the purchase. You don't want to stand in line either. We will stand in a line sometimes for a concert or for a ball game when we're trying to cram 50,000 or 100,000 people through those gates in a short period of time for a definitive time when something starts. That's about the only time that Americans stand in line.

Canadians, the British, the Europeans, they stand in line for health care. It's appalling the standing in line that they do. Russians stand in line as a matter of course. It's part of their culture. It's the living that they make, apparently. I think they wander around Moscow looking for another line to stand in. They've been so conditioned to stand in lines. They hunch their shoulders, look down, wander around, look up once in a while, find a line, go get in it, and then find out what the reason is.

Americans don't do that. We have freedom. We are a freedom-loving people, and it's our free markets and our free enterprise and the entrepreneurial nature of this and the innovativeness of it. It's also the property rights and the patents and the trademarks that we have that make this country go, and we are the economic growth engine for the world.

Here is an example of the Canadian model—and they're our neighbors, and we love them, and we get along great with them, but the Canadian model would be this, and this came out from Senator MITCH MCCONNELL from the Senate side: The average wait time for someone who needs a knee replacement in Canada—a knee replacement—is 340 days. Can you imagine? Finally, your knee wears out, and you're using a cane or you're on a crutch or you're in a wheelchair or you're sitting around the living room or you're not going back to work. You go to the doctor, and he takes a look at your knee and schedules you for a knee replacement. He looks on the calendar and turns the pages—1, 2, 3, 4, 5, 6, 7, 8, 9, 10 months, 11 months. He turns the page 11 times on the calendar to find the date that he can write your name in. You have to go 340 days to get your knee replacement in Canada.

Yet we would just leap into the abyss of socialized medicine because the President's idea is that the government can do it better than the private sector can? We just have to learn how to do it better than the Canadians, the British or the Europeans?

How about the average time for a hip replacement in Canada? According to MITCH MCCONNELL, the average time is 196 days for a hip replacement. So your hip socket wears out. Now, that's a little tough to do that always with the cane, although it happens. You're on a crutch or two crutches or you're on a cane or you're in a wheelchair gimping around for 196 days. You know, I don't know if you call that ''elective surgery.'' I don't think it is. I think, at some point, for the quality of your life and for your productivity, the necessity is to get the surgery done.

That's rationed health care. I don't know the numbers of how many people died of something else while they were waiting to get their knee joints replaced or their hips or how many of their lives were altered because of it or how much was diminished of the quality of their lives, of the people who had to wait in those lines. That's just joint replacement.

I had a meeting last night with a doctor who does orthopedic surgery in Canada and in the United States. He goes back and forth across the border and does that work. He told of the case of a patient who had come in who had torn up his knee. He said a torn meniscus, and I believe he said an ACL, an anterior cruciate ligament, those two things. It was a knee wreck—swollen and badly painful. He was up there, and he did the examination, and he said, Fine. We'll get you into surgery right away, and we can fix you. We'll patch up that ligament, and we'll patch up the torn meniscus, and we'll fix you.

□ 1600

In America, that surgery would happen, oh, the next day. They might elect to allow the swelling to go down—that could happen—but it could happen also that the surgery could be the same day or the next day if the surgeon decided that was the best thing for the patient. And that would be the criterion, by the way.

But in Canada, he did everything he could to schedule him with the proper

surgeon, and this man had to wait 6 months to be further examined before they could evaluate whether they would schedule him to repair his knee.

So they put him in a brace, sent him out of there on crutches, and 6 months later he showed up at the specialist who examined him and scheduled him for surgery 6 months later. A torn knee, a year wait, almost a year to the day from the date of the injury to the date of the surgery. And then, of course, he has the rehab time on that before he's back and limbered up before he can go back to work.

This individual wasn't productive for more than a year, lost more than a year's wages. Why? Why would we waste this human collateral that we are? The most precious resource that we have in this country is our people. And we need to become the most productive people on the planet.

One of the jobs that we do here in the House of Representatives—we should be doing here—it would be enhancing the overall average productivity of all of our people in this country. And if we do that, we'll also increase the quality of life for everyone in this country.

When we diminish it by disrespect for life, whether it's the unborn, whether it's someone who was injured that would be allowed to lay off over on the sofa or sit in the living room chair and not be going to work when they could be fixed in a short period of time and back into it again, that's what happens in countries that have socialized medicine, national health care, a Federal public payer plan which has been devised in those countries that I mentioned, but not in the United States, in part because the American people from 15 or 16 years ago saw this schematic and they were as appalled and animated by it as I was.

And they got on the phone. They called their Congressman; they called their Senator. And they came to Washington, and they jammed the offices full of people. And they went to the offices of the Members around the country.

They wrote letters to the editor and letters to their Members of Congress. And they got on the radio programs that existed at the time—and some of them did—and the American people had a dialogue about how they wanted their health care to look and what they wanted to maintain.

And they completely rejected this model, this old model from the early 1990s, this alarming model of creating all of this growth in government that nobody can completely understand, maybe Hillary understood what she wanted to do. And look at this: the government agencies and programs interact. Some of these I recognize, Department of Labor. I don't know what PWBA is or NGFSHP, NQMP. I think I knew at the time.

But all of these government agencies created or interacted—look at this. The global budget. This is part of the HillaryCare plan. And I will submit this scary HillaryCare plan is not as scary as the 3–D technicolor modern plan, the ObamaCare plan, that has emerged in this Congress that has the idea that it's going to squeeze out the private health insurance in America.

How about the Bureau of Health Information? They will aggregate your health information. The Health Choices Administration, HCA. Health Choices Administration Commissioner.

We know what's happened. America has run out of patience with czars so we're not going to see very many more czars, I don't believe. I mean, 32 may be like our threshold, the political threshold of the number of czars that we can have in America. So we start naming them ''commissioners'' instead. Commissioners aren't as alarming as czars. Commissioners weren't the precursors to Marxism in the Soviet Union. So we're not as alarmed when we call them ''commissioners.'' So we have the Health Choices Administration Commissioner.

Health choices. What does that mean? That means if the doctor doesn't make the choice that's consistent with the directive of the Health Choices Commissioner, they are going to find the doctor. And we don't know what that amount is yet, but it will be hefty. And if the doctor then doesn't comply a second time—not defies necessarily—but just doesn't comply with the Health Choices Administration Commissioner, the second time the bill provides that he face jail time.

Now, are we going to lock up doctors because they keep their Hippocratic Oath and they do no harm and they order the kind of services that protect people? Are we going to ration health care? Are we going to let the government set this entire standard for the entire United States of America? And why would we do that when we realize that in Canada there are whole companies that have sprouted up in Canada. Just think of them as travel agencies that merged with health care services.

And they realized that the Canadians—there is a law in Canada that prohibits a person from jumping to the head of the line when it comes to health care services. So if you have a bad knee, you're going to wait 340 days. It's against the law to move ahead in the line, jump ahead in the line. Nobody wants to be in a line that's getting longer while you are standing in the back of it.

If you hurt your hip, a 196-day wait. But there are people in Canada that can't wait. They can't wait for a hip. They can't wait for a knee and certainly not for heart surgery, and many do.

So some of the companies, Canada, have a policy that's set up as part of their employment policy. And when they recruit some of their employees, the package will be, Here is your salary package, here's your retirement plan. And by the way, we have this plan for you. If you need heart surgery, we'll package this thing up and we'll fly you down to Houston for heart surgery or Ann Arbor or maybe Rochester, Minnesota, at the Mayo Clinic. This happens on a regular basis.

The travel agencies that merged with the health care-providing agencies provide the turnkey operation. Let's say you need heart surgery in Houston. Companies will set this up for the individual that can't wait in line, can't live for the line to get short enough that he can get the treatment, so they package this up and it will be, Here's your round trip plane ticket from Toronto to Houston. Here's a hotel you will go to, here's your transportation on the shuttle bus from the airport to the hotel. And the clinic is next door. You'll go over for the examination at X time on this morning. If all of these things hold up and they are comparable, then you'll go forward with the surgery at such and such a time at this location.

Here's what it will cost for all of the items: the surgeon, the anesthetic, the operating room, the list of all of the incidentals that go into this. They package it all up, you write one check, and American health care saves your life. So does the entrepreneurial nature that sets up those businesses in Canada to access American health care.

But what a cruel thing to do to the Canadians to adopt their plan or a plan similar to them. ObamaCare health care, where then do the Canadians go when they need health care that's urgent, that's life saving, or turns them back into productive citizens again? They've got their relief valve of the United States today. This scary, multicolor, technicolor—we'll turn this into 3–D I hope one day—model says to the Canadians it could be the end of their options. They could say to the American people that it's a whole series of different things that we've never had to think of before

Why would we give up our freedom? Why would we give up our freedom when 70 percent of us like the health care systems that we have and the health insurance plans that we have? And the argument that comes from the Democrats consistently is there are 44 or 47, or they will often say almost 50, million people that are uninsured in America. Well, I guess if there is a plan for Canadians and they don't have to sign up for it, just show up at the emergency room, if they're not signed up, they're uninsured, too.

If you've got a program that takes everybody, whether they're signed up or whether they're not—I wonder how many people are actually signed up in Canada—but if the number is let's just say 44, maybe on the outside 47 million, I can take you this way, Madam Speaker, and that is that out of those 44 or so million people, you've got to subtract from that the illegals that are here in America.

I don't think anybody seriously wants to provide a health insurance program for people that jump the border illegally and sneak into the United

States and that are working here illegally and violating our laws. I don't think we want to fund that. I don't think we want to give them the Cadillac of what would be left of our health care program. So I would subtract those out of that list.

We can debate what the size of that number is. Some say 11 million. I've been here now—this is halfway through my seventh year. We've been saying 11 or 12 million illegals in America since I arrived here in this Congress. I have gone on down on the border and watched them pour across the border at night, participated in catching a few of them, including a significant supply of illegal drugs that come with them. The number of border crossings that we have had on average since we've been here, the illegal border crossings where we catch them average more than a million a year since I have been in this Congress.

So we've caught over 6 million, probably closer to 7 million who were trying to cross the border and get into the United States.

The Border Patrol, when you ask them what percentage do you catch, some will say 25 percent. That's actually the official line in the testimony before hearings, from the Border Patrol themselves, but when I ask them that question, they will laugh at me. They will say, Oh, no. Not that many. Perhaps 10 percent.

Well, I'll take the 25 percent number and multiply that times the 7 million illegal crossings that we've caught and just say that's three times that number that have actually gotten into the United States successfully if we're intercepting only one out of four.

You've got four, three get across, one we caught. He goes back. That's how that works. And I guess it's three times the number. Three times 7 million is 21 million. That's 21 million that came in. Some died. Some went back. But that's one way to measure how many illegals have come into the country as soon as I have been in Congress. And if you add that number to the roughly 12 million number, now we're up in the 30-some million category.

And it's easy, Madam Speaker, to understand why I think the numbers of illegals in this country are probably greater than 20 million. And we know that the numbers of those working in this country is a number that's over 7 million working in this country at least, and that is a Federal data point number.

But if we cut the illegals out of that list of 44 million of the uninsured, and then if we subtract from that number those that are just in transition between one health insurance plan to another, then we get down to a number that's a little more understandable. And it's a number that comes from two Penn State professors who did a study some years ago. And if I remember correctly, their number was that there was about 10.1 million Americans that are part of the chronically uninsured.

Now, we should be addressing not the illegals, not those in transition between their health care plans because they're going to find another one and they're going to likely stay on that one. There is always that happening while people are looking for the best plan.

But if we really have something to fix, we should be fixing the chronically uninsured, that 10.1 million. And I think I took that and divided it by the population and rounded it up to the nearest percentage point. Take 10.1 million, divide it by 300 million and you end up with a number that's a little over 3½ percent.

So let's give the benefit of the doubt to the liberal utopian people who draw up these schematics that we're trying to fix something like 4 percent of the problem. Four percent of the population is chronically uninsured, and we would tear apart the entire system to try to fix this 4 percent. And what percentage of the 4 percent will be fixed?

Well, according to one of the estimates on how the result of those that would be recruited by this plan would work out, this plan pushes tens of millions off of their own private insurance plan. Puts them on the government plan. And in the end, the result would be such that they ended up—by one measure, 97 percent of America would be insured. But I don't think that includes that—I don't know how they address the illegals.

Well, we have now 96 percent. By the time you take out the chronically uninsured and the illegals, 96 percent of America is now insured. Now, I don't want to argue that of the chronically uninsured, this plan would only get 25 percent of them enrolled. It may not be. But if you want to look for a measure on what's likely to happen, one need go no further than the Medicaid rolls in America. There it is, if you qualify. Sign up for Medicaid. It's a free program. You don't have any responsibilities except to sign up, and you will be covered if you meet the standards of the lower income that's necessary.

But of those that are eligible for Medicaid in America, just slightly over 50 percent of them are actually enrolled. So why would we think that we could enroll the part of that 4 percent of the chronically uninsured; why would we think we could get a higher percentage of them to enroll in a government plan, or furthermore, if they're no more responsible than that, why would we want to? What is the upside?

□ 1615

Aren't there other solutions and better solutions? And the answer to that question of course is yes and yes. There are many better solutions than what's being proposed in this particular outrageous and scary schematic.

We should do many things. We should expand our health savings accounts. One of the best things we did with health care in this Congress in this last decade is to pass health savings accounts, and if a young couple in that year, say at 20 years of age, had invested the maximum amount in their health savings account that year and done so each year—first year was $5,150 and it's indexed for inflation, moving on up. I don't know the number today any longer; I've lost track. But I did do the math on this and build a spreadsheet to do the calculation.

If that couple at age 20 invested the max in their health savings account and did so each year until they reached Medicare eligibility and spent $2,000 of real dollars out of that account in legitimate health care costs for each year, and you accrued that at about a 4 percent rate, which was legitimate at the time I did the math—and it will be legitimate—again, that couple arrived at retirement age with more than $950,000 in their health savings account.

Now, why wouldn't we as a Nation take a look at that, utilize that, and give them a reward for their responsibility and see if we can find a way to make a deal with them that will get them off of the entitlement roll and because they have the assets to take care of themselves? And I would argue this, Madam Speaker.

I would say to that couple, take your $950,000 and buy a paid up Medicare replacement policy and keep the change tax free. Right now, the intent of this Congress is to tax those health savings accounts when either they are spent or when the people that own them die. They want to tax that. I say, if they will take themselves off of the Medicare entitlement rolls, I want them to have the balance of that tax free.

We can work out some formulas where we can actually help them buy that out, but today, let's just say if a couple, similar couple, arrived at age 65 today and they wanted to do an altruistic thing and not be part of the Medicare entitlement, they could buy a Medicare replacement policy for right at $72,000 per patient. So, say, a husband and a wife, for $144,000, could buy a replacement policy. That would be the cost, I should say. I don't know if you can actually buy the policy these days because government has monopolized health insurance for people past the age of 65, but that's the risk, that's the average risk for the health care costs. From 65 until natural death, it would be $72,000 per individual.

So it's reasonable to think that we could set up a Medicare replacement policy that people could buy and let them cash the difference tax free. That would be a great incentive for a lifetime. It's one of the things we can do.

Another thing that we need to do is increase the amount that can be deposited into the health savings account; in addition, medical malpractice. You can look through all of these schematics, this Technicolor schematic of the modern day ObamaCare version or one can look through this black and white

older version of the HillaryCare health care schematic, and you can't find anything in here about the reform of the unnecessary, punitive malpractice litigation that's taking place all across this country.

We all know about the lady that spilled a cup of coffee from McDonald's in her lap, and she was awarded in the initial decision—I forget the number now—$3 or $7 million or whatever outrageous number that was, and I know it went back under appeal, and it lowered the number down, but it surely intimidates people.

A case here in town, it wasn't medical, but it was a judge that sued a cleaners and took one or two of their stores out of business because they lost his pants. And we see businesses out because of litigation that's brought about in that fashion.

How many tests are done in America because the doctor is paying a very high malpractice premium? In order to protect himself from a suit, he has to run a bunch of extra tests because that's what you do in the industry to protect yourself from the lawyers. First, take the oath to do no harm, go out to serve people in a profession that has great honor, and have it be framed by fear of litigation instead of doing the right thing. That's the medical version of a good Samaritan watching someone get run over on the street and not going to help them—well, a formerly likely good Samaritan that's afraid they will get sued because they will reach outside of their profession in an effort to help somebody and they get sued. And doctors run tests every day by the thousands to protect themselves from litigation.

And yet, nothing in the old schematic and nothing in the new Technicolor schematic addresses the medical malpractice insurance. Now, we addressed it in the Judiciary Committee a few years ago, and we put a cap on noneconomic damages of $250,000. That is what they have in California. Not a lot of good things happen legislatively in California, but that's one that did. Proposition 209 was another, just to toss an aside into this dialogue. But we capped it at $250,000 noneconomic damages and let people be made whole. If they were injured by malpractice, they would get the cost of their medical care. They would get real economic loss of income. They would even get a little pain and suffering, but the punitive damages, the things we consider to be punitive damages that were defined in the bill as noneconomic damages, would not be awarded beyond $250,000.

Why would you pay a lady millions of dollars for spilling a hot cup of coffee in her own lap in order to send a message that McDonald's shouldn't serve hot coffee? How many things in this life do we no longer have access to because a trial lawyer's figured out a way to make a living and then the other lawyer's figured out a way to write the rule so that we could avoid that kind of litigation?

How many of us have climbed into a vehicle and gone down the road and decided, I want to program my navigator, and found that your navigator doesn't work while you're moving because some lawyer decided you might get in a wreck for programming your navigator, and then sued the manufacturer for being distracted from your driving? Why is it their fault if you don't have responsibility? But instead, they put the failsafe in so you have to pull off on the side of the road, and a lot of it, they defeat the intent of having that kind of a device.

That's what goes on with health insurance as well. That's what goes on with health care providers. A very high cost in health care in America is because of unnecessary tests that are being run in order to avoid litigation.

So maybe if we had all doctors that were paid by the government, then they would have the sovereign immunity that would come from being Federal employees so they wouldn't be sued. Now, that might be a way where Obama might save some money on health care. I don't want to go there, but it might be the only thing that actually might be legitimate as far as saving money, and then they will argue that they will reduce some of these costs down by providing efficiencies through technology. I will support that.

Let's have better records. Let's have those records be easily and quickly available to qualified people so if you live in Kansas City and you end up in the hospital in San Francisco, they can do a quick bar code off of your driver's license, for example, and access your health care records so they know what you're on for prescription drugs; they know what kind of treatments that you had. You may not be conscious and there may be no one with you. Even if they are, they may not know what you're taking for medication. Let's do that technology.

Do we have to do this in order to utilize more modern technology? We are moving in that direction with the technology anyway. I suppose the health care czar will tell us just what technology we can use and set some mandatory parameters on how we get there. I am nervous about that.

So there are some efficiencies. There are wellness plans that can be incorporated into health insurance programs that are incentives, and if we have those incentives there, people will do the right thing. If you lower my health insurance premium, I'll lose a few pounds and I'll exercise a little more and I'll go in for a checkup a little more, and they will diagnose the problems earlier, and we'll live longer and healthier as a people. That's the free market. That's not a one-size-fits-all socialized medicine plan.

These are the things that we should be looking at to improve our health care systems here in the United States, but going down this path, going down this path of creating the huge bureaucracy, the Health Benefits Advisory Committee, imagine what that is; the Public Health Investment Fund, oh, how they manage your dollars while it's in there. What else do we have? We have the mandate by insurance that goes down to the consumers, the Health Insurance Exchange Trust Fund, the Clinical Preventative Services Task Force. So that's going to be preventative services.

Another thing that happens when you have socialized medicine—I will tell this in a narrative the way I heard it. When this plan went in in Canada, at that time I had a good number of business relationships with friends in Canada, and they gave me the unfolding narrative. One of them—his name was Peter actually—said to me, here's what's going on. They passed a national health care plan in Canada, the socialized medicine plan, and they said you need to be responsible and go to the clinic for your checkups and don't overload the emergency rooms and treat your health care in a responsible fashion and only go when you're sick, don't go when you don't need to except for your regular checkups, be a responsible consumer. That's how it was sold. And by the way, they did the actuarial projections on the cost by expecting Canadians to be responsible consumers.

And he said, so, the first year of the national health care plan in Canada worked like this. People were respectful. They did go to the clinic. They didn't crowd the emergency rooms, and it went along pretty good for the first year. And by the second year, the third year and the fourth year, people weren't willing to take time off from work to go to the clinic when it was convenient for the doctor. So, on the weekends and at nights when they did have time in their schedule, they just went to the emergency room and abused the privilege.

And so Peter explained it to me this way. He said, it was just like a company that for the first time was having a Christmas party and they invited all the employees in to have a dinner and a few drinks and to celebrate Christmas together. And everybody comes and they have one or two drinks and they tell good stories about the boss and pat him on the back, and everybody was just nice and full of love and responsibility and grateful that they'd had a Christmas party that they could celebrate together as a working family, or a family of workers to be more correct.

But he said by the second or third and the fourth year of the socialized medicine plan in Canada, it was like the second, third or fourth year of the company Christmas party. They abused the privilege. They drank too much. They told nasty stories about their boss. And they expected their Christmas party and the bonuses to be an entitlement rather than a bonus.

And so that was the attitude that he described of the Canadians: jamming the emergency rooms when they went

at the times that was convenient for them, not going to the clinics, not being responsible, and that they had abused the privilege. And the costs went up and the service went down and the lines got long and people died in line. That's the tragedy. That's the tragedy of socialized medicine.

I met a man a few months ago in a home improvement center, and he was an immigrant from Germany. And he told me about his hip surgery. It wasn't a sad story. It was matter of fact the way he delivered it. He had to wait about 6 months to get a hip replaced as a German, but he wanted it done badly because it was painful and it limited his options on how he could move around and what he could do. And so he had to travel from Germany down to Italy where the line was shorter, and he was operated on in fewer days than if he had been waiting in line in Germany.

And I listened to that story, and I thought, what would it be like to have to go to another country to get your health care because the lines are shorter? What would it be like to get your health care because there's a line? We're Americans. We don't stand in line. We have freedom. We have fought for that freedom. We have worked for that freedom. We've paid for that freedom. We don't stand in line. We don't make ourselves dependent upon bureaucrats to make decisions on what's better for all of our lives. We go out and make our lives better. That's what we are. That's who we are.

And this color-coded schematic threatens our freedom. It threatens your freedom. It diminishes the spirit and the character of the American people and turns us into dependents. It takes the safety net that we have today and it cranks it up a few notches and turns it into a hammock. And we take less responsibility, and the psychology of who we are as a people are diminished. What about that American spirit, that can-do spirit? That idea that we can do anything?

□ 1630

The idea that we can go to the Moon, if we decide we can go to the Moon. What about what happened when the Japanese attacked Pearl Harbor? We took on a national mission and a two-front global war and put 16 million men and women into uniform and came out of the other side a global power and the only surviving industrial power in the world.

We set the pace with our economy, with our politics, with our culture, with our faith and our values, and an inspiration for the world. The rest of the world looks up to us. They do see what's been accomplished here. And we have taken the talent of every culture in the world and rolled it together in this great melting pot and come out of it with something that is a unique vitality, a unique vitality that doesn't exist in any other people in the world, in part, because we've skimmed the cream of the crop off of every Nation in the world.

The people that came here, came here because they wanted to have a chance at the American Dream. They wanted to have an opportunity to become an American and an opportunity to be independent economically and carve out and pull themselves up by their bootstraps and provide for their own family and sit down at the supper table at night and be proud of what they have accomplished for their day, for their week, for their month, for their life.

And we should be proud of what's been accomplished in this country by the lives of all of those that have gone before us. This is not worthy of their effort and sacrifice. This isn't worthy of a proud and independent people that should be reaching for more freedom instead of giving it up in exchange for dependency.

This is dependency. It goes the wrong way. It takes us to the left. It takes us to a dependency. It takes us to a myopic image of a utopian version where they have always thought—and let's just say in that part of Western Europe your utopian thinkers have emerged. They have always drawn these kind of schematics to come up with a better way to be able to find this utopia on Earth.

They completely and diametrically are opposed to the philosophies of Adam Smith and the philosophies that emerge in the Old and in the New Testament.

The independence that we have to have, the personal responsibility that we have to have, the moral standards of the core of who we are as a people, diminished by this color-coded schematic.

And I pray, Madam Speaker, that the independence of the American people, the spirit that's within us, the inspirational responsibility that we have for the world, will cause us to rise up and reject this model, this model that's not for Americans.

It's not an American thought process to always be taking responsibility away from people and diminishing their freedoms in the process. We need to be about expanding freedom, not diminishing freedom. And when we do that, our spirit rises up to the top. Our energy and our work ethic rises to the top. And we are stronger economically. We're stronger as family. We're stronger as faith. We're stronger as a culture and as a people, and we need to do that to set the inspiration for the rest of the world.

Somebody's got to lead. This is our time, and I challenge the people in this Congress and this country to do the right thing by this policy.

With that, Madam Speaker, I thank you for your indulgence, and I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. GRAVES (at the request of Mr. BOEHNER) for today on account of attending a funeral.

Mr. LUCAS (at the request of Mr. BOEHNER) for July 15 after 4 p.m. and the balance of the week on account of a family commitment.

Mr. GARY G. MILLER of California (at the request of Mr. BOEHNER) for today on account of family reasons.

Mr. WESTMORELAND (at the request of Mr. BOEHNER) for today on account of family medical reasons.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. WEXLER) to revise and extend their remarks and include extraneous material:)

Ms. WOOLSEY, for 5 minutes, today.

Mr. WEXLER, for 5 minutes, today.

Mr. SCHIFF, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Ms. BERKLEY, for 5 minutes, today.

(The following Members (at the request of Mr. POE of Texas) to revise and extend their remarks and include extraneous material:)

Mr. BURTON of Indiana, for 5 minutes, July 20, 21, 22, 23 and 24.

Mr. POE of Texas, for 5 minutes, July 24.

Mr. JONES, for 5 minutes, July 24.

ADJOURNMENT

Mr. KING of Iowa. Madam Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 4 o'clock and 33 minutes p.m.), under its previous order, the House adjourned until Monday, July, 20, 2009, at 12:30 p.m., for morning-hour debate.

OATH FOR ACCESS TO CLASSIFIED INFORMATION

Under clause 13 of rule XXIII, the following Members executed the oath for access to classified information:

Neil Abercrombie, Gary L. Ackerman, Robert B. Aderholt, John H. Adler, W. Todd Akin, Rodney Alexander, Jason Altmire, Robert E. Andrews, Michael A. Arcuri, Steve Austria, Joe Baca, Michele Bachmann, Spencer Bachus, Brian Baird, Tammy Baldwin, J. Gresham Barrett, John Barrow, Roscoe G. Bartlett, Joe Barton, Melissa L. Bean, Xavier Becerra, Shelley Berkley, Howard L. Berman, Marion Berry, Judy Biggert, Brian P. Bilbray, Gus M. Bilirakis, Rob Bishop, Sanford D. Bishop Jr., Timothy H. Bishop, Marsha Blackburn, Earl Blumenauer, Roy Blunt, John A. Boccieri, John A. Boehner, Jo Bonner, Mary Bono Mack, John Boozman, Madeleine Z. Bordallo, Dan Boren, Leonard L. Boswell, Rick Boucher, Charles W. Boustany Jr., Allen Boyd, Bruce L. Braley, Kevin Brady, Robert A. Brady, Bobby Bright, Paul C. Broun, Corrine Brown, Ginny Brown-Waite, Henry E. Brown Jr., Vern Buchanan, Michael C. Burgess, Dan Burton, G.K. Butterfield, Steve Buyer, Ken Calvert, Dave